

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2012
FORM APPROVED
OMB NO. 0938-0391

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|---|--|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/07/2012 | |
| NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 | | | |
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| F0000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 4, 5, 6, 7, 2012</p> <p>Facility number: 000012 Provider number: 155029 AIM number: 100274900</p> <p>Survey team: Connie Landman RN TC Diana Zgonc RN Lora Brettnacher RN Christi Davidson RN</p> <p>Census bed type: SNF/NF: 104 Total: 104</p> <p>Census payor type: Medicare: 16 Medicaid: 74 Other: 14</p> <p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/12/12 Cathy Emswiller RN</p> | | | F0000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F0279 SS=D | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop care plans for each resident that included measurable objectives and timetables to meet each resident's assessed needs for 1 of 40 residents who met the criteria for care plans (Resident #74).</p> <p>Findings include:</p> <p>1. Resident #74's record was reviewed on 6/6/2012 at 9:30 A.M. Resident #74 was admitted on 11/1/2012 and had current diagnoses</p> | | F0279 | <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after 7/2/12 F279 Develop Comprehensive Care Plans It is the practice of this provider to ensure that every resident has a comprehensive care plan that includes measurable objectives</p> | | 07/02/2012 | |

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| | <p>which included but were not limited to paranoid schizophrenia, diabetes mellitus, history of a cerebral vascular accident (Stroke), history of urinary tract infections, cystitis, and seizure disorder.</p> <p>A current physician's order on the signed June 2012 recaps indicated Resident #74 was taking Fluphenaz (anti-psychotic medication) 25 MG/ML (milligrams/Milliliters) injection intramuscularly and Fluphenazine 2.5 MG tab twice daily for the diagnoses of schizophrenia.</p> <p>Resident #74's record lacked a care plan addressing anti-psychotic medication usage.</p> <p>During an interview on 6/7/2012 at 10:15 A.M., The DON (Director of Nursing) indicated he would expect any of the residents on anti-psychotic medications to have a care-plan addressing the potential side affects. He further indicated if this resident did not have one he would have one today.</p> <p>On 6/7/2012 at 10:30 A.M. the DON provided a care plan dated for 6/7/2012 addressing Resident #74's psychotropic medication. Prior to this date there had not been a care plan</p> | | | | <p>and timetables to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? At the time the deficiency was identified, a care plan for resident #74 was put into place addressing anti-psychotic medication usage and addressing bowel and bladder incontinence. A full house audit on ADL coding for continence will be completed by Minimal Data Sets Coordinator to ensure that those residents with incontinent episodes have appropriate care plan in place. A full house audit will be completed by the Social Services Director or designee on those residents receiving anti-psychotic medication to ensure that appropriate care plan is in place. The Minimal Data Sets Coordinator or designee will educate facility aides and nurses on resident ADL coding in regards to continence, toileting, and assistance. This will occur on 7/27/12. The Minimal Data Set Coordinator will educate the Social Services Director and designee on Care Plan Development in regards to anti-psychotic medication usage. This will occur on 7/21/12. How will you identify other residents having the potential to be</p> | | |

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| | <p>for this resident regarding psychotropic medication use.</p> <p>Review of a significant change MDS (minimum data set-assessment tool) dated 1/25/2012 indicated Resident #74 had a decline in urinary incontinence and was occasionally incontinent. Resident #74 had chronic psychiatric problems, urinary urgency, a need for assistance to the toilet and urinary incontinence would be care planned. Review of a quarterly MDS indicated Resident #74 was occasionally incontinent and not on a toileting program. Resident #74 required limited assistance of one staff for toileting.</p> <p>Resident #74's record failed to contain a care plan for urinary incontinence.</p> <p>During an interview on 6/6/2012 at 4:00 P.M., The Administrator was asked if Resident #74 had a care plan which addressed urinary incontinence.</p> <p>On 6/7/2012 at 10:15 A.M., the DON (Director of Nursing) provided a care plan which indicated Resident #74 was occasionally incontinent due to a history of cerebral vascular accident (stroke) and chronic cystitis. This</p> | | | <p>affected by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the potential to be affected by this alleged deficient practice. The Minimal Data Sets Coordinator or designee will educate facility aides and nurses on resident ADL coding in regards to continence, toileting, and assistance. This will occur on 7/27/12. The Minimal Data Set Coordinator will educate the Social Services Director and designee on Care Plan Development in regards to anti-psychotic medication usage. This will occur on 7/21/12. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? To ensure compliance, the MDS/Designee is responsible for the completion of the Bladder and Bowel elimination CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. To ensure compliance, the DNS/Designee is responsible for the completion of the Anti-Psychotic Medication Use CQI tool weekly x 4,</p> | | | |

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| | <p>care plan was dated created on 6/7/2012. Prior to this date there was not a care plan which addressed Resident #74's urinary incontinence.</p> <p>3.1-35(a)</p> | | | <p>bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. To ensure compliance, the DNS/Designee is responsible for the completion of the Care Plan Review CQI tool weekly x 4, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Bladder and Bowel elimination CQI will be reviewed monthly by the CQI Committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Anti-Psychotic Medication Use CQI will be reviewed monthly by the CQI Committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Care Plan Review CQI will be reviewed monthly by the CQI</p> | | | |

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| | | | | Committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 7/2/12 | | | |